HEALTH OF THE AGED

by

Helen B. Shaffer

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THE STEADY INCREASE in the proportion of older persons in the population of the United States has raised concern over present obstacles to adequate medical care for millions of American men and women in their declining years. The medical needs of the aged far exceed those of persons in the lower age brackets, and fewer of them have the private means to command the required professional attention.

After age 65, health services of various sorts may rank with food, clothing, and shelter as essentials of life. For the process of growing old, in the words of a leading world authority, can be considered "a disease consisting of deficiencies and illnesses—a chronic and fatally progressive disease." [1] Gerontologists and others have pointed out that, for those without independent incomes, lengthening of life too often means mere prolongation of years of physical and mental suffering.

Solutions to health problems of the aged are being sought through (1) development of feasible methods of defraying the disproportionately high medical costs of this group of the population by means of health insurance or otherwise, and (2) organization of facilities not only to care for the sick and infirm but also to maintain all older persons at their highest possible levels of well-being and independence.

In addition, a major scientific inquiry into the problems of aging is getting under way this autumn at Duke University in Durham, N. C. The regional research center to be established there, with the aid of U.S. Public Health Service grants, will be the first of its kind and may serve as a model for similar projects in other parts of the country. When plans for the center were announced, Aug. 3, Dr. Edward W. Busse, chairman of Duke University's Council on Geron-

[1] Opening address of Dr. Enrico Greppi, president, to fourth annual congress of International Association of Gerontology, Rome, July 15, 1957.

tology, said its objectives would be to help slow the aging process, promote the health of elderly persons, and delay or prevent their entry into institutions.

Growth in Number and Percentage of Elderly

Although health problems associated with aging have only recently begun to receive special attention,[2] the general progress of medical science and the spread of public health measures during the past 50 years have added 22 years to the life expectancy at birth of the average American. Between 1900 and 1950 the total population of the United States doubled, but the number of persons aged 65 or over quadrupled. At the turn of the century only one in 25 Americans had passed his 65th birthday; now one in 12 has reached normal retirement age. The average person who lives to be 65 can look forward today to from 13 to 15 additional years of life.

Approximately 14,750,000 persons in the United States are aged 65 or more, and their number is increasing at the rate of about a thousand a day. Some 4½ million have passed their 75th birthday; two million of these are in their 80s or 90s. In another ten years, even without any significant increase in longevity, around 20 million Americans will be in the upper age brackets.

Bearing on the health problem of today's elders is the fact that social and economic changes have deprived large numbers of them of protections enjoyed by their parents and grandparents. In earlier years, when the country was predominantly rural, ownership of land and the self-sufficiency of family farms gave the aged and the aging a substantial measure of economic independence. At the same time, they could depend on the ministrations of younger members of the family if they fell sick or were disabled. A Boston physician has suggested that now "the immense degree of fear and frustration associated with growing old in our society" may account for the relatively high incidence of senility in this country; in the Orient and the South Seas, where old age is esteemed, "senility is not a common problem." [3]

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[2] "In comparison with other health fields, aging has yet been little explored. There is much we have to learn about the aging process and about the diseases that affect older people."—Dr. Leroy E. Burney, Surgeon General, U.S. Public Health Service, *Washington Star*, Aug. 13, 1957.

[3] David D. Stonecypher, Jr., "Old Age Need Not Be 'Old,'" *New York Times Magazine*, Aug. 18, 1957, p. 27.

Today more and more old persons or couples live alone in urban places. Their support comes from pensions, Social Security benefits, personal savings, the return on small investments and, in some cases, earnings. Income from these sources is usually small and fixed in amount. When illness or disability strikes, the elderly often must seek the help of public agencies.

Many retired persons remain in reasonably good health, have sufficient means, and lead active lives. But the number who eke out bare livings on tiny resources while suffering debilitating illness or other handicaps is sizable and growing. Even those still in good physical condition face hazards of sudden, long-term illness which can wipe out a family's resources in short order.

LACK OF FUNDS TO MEET INCREASING DOCTOR BILLS

The past 20 years have seen striking advances in provision of independent cash income for the aged. Seven million receive benefits under the Social Security retirement program. Another 1.8 million are pensioners under public programs for civil service and railroad workers and veterans; one million receive private pensions. In all, 10.7 million or three-fourths of all aged persons have some income from earnings or social insurance or both. Another 2½ million, most of them in top age brackets, are on public assistance.

Old age benefits or relief payments, however, scarcely stretch to cover the costs of serious illness and may not even provide the margin over necessary expenditures required to pay for ordinary medical care or health needs. A Census survey of consumer income in 1955 showed that one-fifth of non-institutionalized persons aged 65 or more had no private income and that two-fifths were receiving less than $1,000 a year. Only one-fifth had annual incomes of more than $2,000. Among aged men, some supporting aged wives, two-fifths had less than $1,000, two-thirds less than $2,000. Among women, including four million aged widows, more than four-fifths received less than $1,000.[4]

Low income adversely affects health of the aged in ways other than deprivation of adequate medical care. Skimpy

[4] A minimum budget for aged persons in New York City, compiled by the city's Welfare and Health Council in 1954, called for incomes of $2,136 for a couple, $1,617 for a single man, and $1,487 for a single woman. Medical expenses were budgeted at $156 for a couple, $70 for single persons.

meals, lack of recreation, and substandard housing hasten physical decline. It was found in Rhode Island a few years ago that one-half of the aged living in substandard dwellings, but only one-third of the well-housed, were in poor health. Other studies have reported a similar relationship between cash income and physical well-being.

Need for More Data on Health Status of Aged

No statistics are needed to demonstrate that advancing years bring increasingly serious and costly medical problems. There is, however, a widely recognized need for comprehensive health surveys to serve as a basis for effective planning. Data on actual incidence of illness or physical impairment among the aged would help in determining how many facilities of various types are needed to give maximum health protection to the aged at least cost.

Aging has been described as "the failure or slowing of cell replacement, muscular atrophy, tissue desiccation, and lower rate of absorption of some nutrients." [5] The aging process is accelerated by diseases of internal origin, some of which may be controllable by prompt medical attention. Older persons suffer disproportionately from chronic illness. Persons aged 65 or more constitute 9 per cent of the population but comprise 40 per cent of the long-term or permanently disabled. About one-half of all persons in the upper age brackets suffer from a chronic disease or physical impairment or both. One survey of chronic illness shows incidence rising markedly with the years, "particularly the disabling and bed cases." [6] Mild chronic illness in youth often becomes disabling in old age.

A one-day census of hospitals in 1953 by the American Medical Association disclosed that the aged occupied 20 per cent of all hospital beds. A Health Information Foundation survey found that persons aged 65 or over not only have a higher hospital admission rate but also stay in hospitals longer than younger patients. The high admission rate is especially significant in view of the fact that relatively few older persons are protected by health insurance, which encourages use of hospitals, and the additional fact that maternity cases greatly swell the admission rate for the younger group.

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[5] Clark Tibbetts, "Aging: Implications for Public Health," *Public Health Reports*, February 1952, p. 122.

[6] Selwyn D. Collins, "A Review of Illness from Chronic Disease," *Journal of Chronic Diseases*, April 1955, p. 412.

One of every four patients in mental hospitals is more than 65. During the past half century the number of first admissions of aged persons to mental hospitals has multiplied nine times, a rate of increase more than twice that of the entire mental hospital population. Approximately half a million older citizens live in homes for the aged, nursing homes or similar institutions chiefly because they are too sick or infirm to remain at home. About one-fifth of the recipients of old-age assistance are either bedridden or require nursing care.

Higher Costs of Medical Care for Older Persons

Expenditures for all personal health services have been shown by a Health Information Foundation survey to average $65 a year per person for the entire population and $102 for those aged 65 or more. Outlays for doctors' services were found to be 44 per cent higher among the aged than in the general population; hospital costs, 92 per cent higher; medicines, 120 per cent higher. Only dental expenditures were lower for the older group.

A Public Health Service survey of urban family medical expenditures showed a smaller spread between the two groups: $65 for the general population and $83 for the older group.[7] But neither of these reports reflected the great amount of free care extended to older persons or the unmet medical needs of the aged. Other studies indicate that lack of funds for doctors' visits and for medicine is a major handicap among low-income aged persons. Many are in need of dentures, eyeglasses, and hearing aids.

Much of the medical care now received by the aged is supplied at public expense. The Health Information Foundation has estimated that at least 12 per cent of all costs of personal health services for persons 65 or more years old is incurred by public agencies. Social Security Administrator Charles L. Schottland told a Los Angeles audience, May 28, 1956, that government was assuming financial responsibility for more than two-thirds of the care given the aged in hospitals. More than half of this care is supplied in mental institutions, most of which are publicly supported.

The care of one-half the aged residents of nursing homes and similar institutions is financed, in whole or in part,

[7] Selma Mushkin, "Age Differential in Medical Spending," *Public Health Reports*, February 1957, p. 115.

from public welfare funds. Costs of institutional care on a long-term basis have become so burdensome that only 15 per cent of the elderly patients in chronic disease hospitals are able to meet the whole bill. Many of these institutions are supported by public or philanthropic agencies and receive no payments from patients.

A survey of general hospital use in 1951 showed that about 17 per cent of patients in the upper age groups received care without charge or paid for it out of funds from other than personal resources. When the hospital stay was a month or less, 60 per cent of the aged patients paid the full bill, but when the period of hospitalization was longer than three months, 56 per cent of the patients received free care.[8] The amount of care given at nominal charge by private physicians, who ordinarily scale their fees to patient income, cannot be estimated.

Health Insurance for Elderly Persons

HEALTH INSURANCE is defraying an ever-larger share of the cost of family medical care in the United States, but relatively few of its benefits accrue to the segment of the population most in need of protection. In recent years considerable study has been given to the possibility of developing a financially secure insurance system that would afford adequate coverage for the aged without lifting premium rates to unreasonable levels.

Health insurance is widely regarded as a major resource for future health protection of the aged because it encourages prompt detection and treatment of disease in earlier years and thus reduces the threat of poor health in later life. Relieving the aged from worry over medical bills would in itself be an important contribution to their physical and mental well-being.

Interest in health insurance for older persons is further spurred by the prospect of an increasingly effective senior-citizens' lobby. Insurance companies and the medical profession fear that demands of the aged may lead to compulsory health insurance for the population as a whole.

[8] Social Security Administration, *Health Costs of the Aged* (1956), pp. 87-88.

Gov. Robert B. Meyner of New Jersey told a conference on aging, June 5, 1956, that "We must consider the possibility that the older group may be agitated into political action by our neglect, might vote into office men who made rash promises of financial help which could prove disastrous to our national economy."

Limitations of Insurance Coverage Among Aged

As a result of the phenomenal growth of health insurance since the war, an estimated 22.5 per cent of all medical care expenditures in the United States were met by voluntary health insurance in 1955, compared with 8.3 per cent in 1948.[9] An estimated 116 million persons now have some degree of prepaid protection against medical bills. Coverage, however, is largely confined to the gainfully employed and their dependents; it falls off sharply at age 65 and continues to diminish thereafter.

Health Information Foundation data, gathered in 1953, disclosed that more than 60 per cent of the population was covered by some form of medical insurance, but that only 30 per cent of those aged 65 or over had such protection. Health insurance coverage is less frequent among women, who make up the majority of the older people.

The chief reason the aged have not shared proportionately in the growth of health insurance coverage is that most group plans terminate an individual's protection when he is no longer employed in the covered establishment. Age as such may not be a barrier so long as an individual remains at work, but retirement at any age usually shuts him off completely. However, the concern of labor unions for the welfare of retired workers has led in recent years to provision of more health insurance for upper age groups under insurance plans negotiated by collective bargaining. But these newer agreements have not yet affected appreciably the number of retired persons covered.

The U.S. Labor Department recently studied 300 labor-management contracts providing health insurance protection for more than five million workers. None of the plans set an age limit for eligibility of a worker to receive hospital, surgical or medical benefits, but only 67 extended hospitalization benefits to retired workers; 58 gave them surgical benefits and 35 maintained other medical benefits.

[9] "Voluntary Health Insurance and Medical Care Costs, 1948-55," *Social Security Bulletin*, December 1956, p. 12.

About one-third of the workers with health insurance could look forward to some benefits on retirement.[10]

A recent National Industrial Conference Board survey of group benefits available to employees of 187 manufacturing concerns showed that 137 companies purchased commercial group insurance to meet basic medical expenses of some or all of their workers, but that only 30 companies continued the benefits for employees after retirement. Even this was a marked advance over 1949, when only two of the companies carried health insurance for retired workers.[11]

Blue Cross-Blue Shield plans are the chief suppliers of health insurance for the aged, because they customarily allow a retiring worker to convert his group coverage to an individual "left-employ" contract. It is only recently that this privilege has been available also under group contracts issued by commercial insurance companies.[12] The retirement plan in force in Federal Reserve banks is unusual in that it places retired employees in a separate Blue Cross group and provides for deduction of hospitalization premiums from pension checks.

Individual health insurance, of course, is available to the general public, but it is more expensive than group insurance and contains many more restrictions pertaining to age and general conditions of health. Relatively few commercial insurance companies sell health insurance to individuals past the age of 60. Blue Cross permits enrollment of individuals in 75 areas of the country but usually limits entry of newcomers to a few weeks each year in order to keep down the number of less favorable risks. Only nine of the 75 Blue Cross plans which enroll individuals have no age limit; the usual cut-off age is 65.

Higher Rates for Fewer Benefits After Age 65

When health insurance is available to an older person, he usually has to pay a higher rate and take fewer benefits than a younger person. Although health insurance has been extended to more older people in the past few years, it still has serious limitations. An insurance industry source has pointed out that "Most insurance companies of-

[10] U.S. Labor Department Bulletin, *Older Workers Under Collective Bargaining, Part II* (October 1956), pp. 6-7.

[11] Harland Fox, "Medical Insurance and the Retired Employee," *Management Record*, November 1956, pp. 386-387.

[12] Joseph Zisman, "Private Employee Benefit Plans Today," *Social Security Bulletin*, January 1957, Reprint, p. 9.

fering individual accident and health insurance do not intend that such policies be used for lifetime coverage." [13] Most of the policies are one-year contracts on which the company reserves the right to refuse renewal. Many individual policies exclude certain illnesses to which the aged are prone or do not cover "pre-existing conditions."

It was found last year, through a survey by the industry, that 106 of the 186 insurance companies covered would consider new risks for individual policies above age 60, some up to age 80. However, "in recognition of the substantially higher claim costs encountered in insuring this segment of the population, 25 per cent of the companies increase the premium charge after age 61 and 10 per cent automatically reduce maximum daily benefits in the latter years to avoid a premium increase." [14]

If a retiring worker is allowed to convert his group insurance, he usually has to pay the higher rate for an individual policy. He may lose the advantage of the employer's contribution,[15] and he usually suffers a reduction in benefits. This happens at a time when his income is sharply curtailed and his health prospects are poorest. He has no assurance, moreover, that rates will not go up at a future date; if he dies, his wife may lose the dependent's protection enjoyed under the group plan.

Benefits for workers were cut back at retirement under 28 of the 67 collectively bargained plans reviewed by the Labor Department. Similar adjustments were called for under nearly all of the company plans studied by the National Industrial Conference Board. Twenty-three of the 80 Blue Cross group plans in the country offer fewer benefits after retirement. The usual method of curtailment is to apply benefits on a per year rather than a per disability basis. Some policies require a lapse of time between disabilities to qualify for benefits. Others place a ceiling on benefits allowed during the remaining lifetime of a retired worker. Under such conditions an individual may exhaust his medical benefits early in retirement and have no insurance protection thereafter.

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[13] Continental Assurance Company, *Paid-Up Hospital Surgical Medical Insurance For Retired Employees*, pp. 6-7.

[14] J. F. Follmann, Jr., "Insurance for Older Persons," *Best's Insurance News, Fire and Casualty Edition*, November 1956, p. 52.

[15] Employers paid full costs for retired workers under two-fifths of 67 collectively bargained plans studied by the Labor Department; the individual paid full costs under one-third of the plans and a portion of the costs under the remaining plans.

The cost of insurance varies according to the basic plan, the area in which the policyholder lives, and his age or condition of health. Premium costs for "left-employ" contracts under Blue Cross, providing hospitalization benefits only, ranged in January 1956 from $12 to $60 a year for a single person and from $42 to $90 a year for a family. Typical rates for a Blue Cross-Blue Shield policy, covering surgical and medical as well as hospital costs, ranged from $70 to $200 a year for an aged couple.

Plan for Anticipating Costs of Old-Age Period

Obviously the chief obstacle to insuring older persons against medical expenses is the fact that their greater vulnerability to ill health necessitates high premiums. The cost factor is at the root of the anomaly presented by health insurance for the aged which is too expensive for them to buy and which affords fewer benefits than they need. The solution appears to lie in spreading costs of old-age medical care over the entire productive life of an individual. The key feature of future old-age health plans will probably be funding; that is, accumulation of the sum necessary to meet costs in the later years through regular contributions in earlier decades.

An underwriter has estimated that the cost of hospital insurance benefits for men aged 65 to 70 is from 175 to 225 per cent higher, and for surgical benefits is from 125 to 175 per cent higher, than for men aged 25 to 65. For the 70-75 age bracket, increases in costs were estimated at 250 to 350 per cent for hospitalization and 120 to 250 per cent for surgical benefits.[16]

The estimated increases reflect greater resort to medical facilities for short-term illness as people grow older. And older persons are more than ordinarily susceptible to disabilities of indefinite or permanent duration. Some companies will offer older persons "major medical insurance," which protects against so-called catastrophic illness but requires that the policyholder pay initial costs (usually up to several hundred dollars) and a percentage (usually 20-25 per cent) of expenses beyond that figure. The cost of such insurance is said to be 250 to 300 per cent higher for men aged 65 or over than for men aged 45 to 49.

An official of a large insurance company, which has been

[16] Harland Fox, "Medical Insurance and the Retired Employee," *Management Record*, November 1956, p. 368.

issuing major medical insurance experimentally for the past half dozen years, recently commented on the difficulty of extending broad coverage of this kind to the aged under present insurance methods: "If you see medical costs mount with age as I have seen them in this experiment, you will agree that if the insurance industry is to provide an adequate coverage at a price the older man can pay, the higher costs of aging will have to be redistributed over the adult lifetime of the individual." [17]

The funding principle is already being applied in a new form of basic group health insurance offered by the Continental Assurance Company. Contributions through the years build up a single premium fund, which provides lifetime coverage for retired workers at no further cost and with no reduction in benefits. The plan utilizes the same financing principle as that followed by pension systems. The company estimates that an accumulation for each retired worker at 65 of $1,249.76 will be sufficient to provide a maximum hospitalization benefit of $15 a day for 31 days, $3 a day to a doctor for visits during that period, a $200 maximum surgical fee, and $200 for additional expenses.

Extension of Social Security to Health Field

As the Social Security retirement system, operating on the funding principle, expanded, it was inevitable that it should come to be regarded in some quarters as an ideal mechanism for making health insurance available to the aged. The Federal Security Administrator in 1951 suggested amendment of the Social Security Act to provide hospital benefits to retired workers at an estimated cost of $200 million in the first year of operation. However, the proposal, widely regarded as a Fair Deal device to introduce compulsory health insurance through the back door, was not pressed. In recent months two detailed plans for integrating health insurance with Social Security have been put forth, one by organized labor and the other by a committee of a state medical society.

The American Federation of Labor-Congress of Industrial Organizations proposes that the Social Security tax be increased to provide insurance for hospitalization, surgery, and nursing home care for all persons eligible for

[17] A. M. Wilson, "The Future of Major Medical," *Best's Insurance News, Life Edition*, April 1955, p. 86.

Social Security retirement benefits. These persons would include not only retired individuals but also over-age workers still on the job, and widows of covered workers with children under 18.

Benefits would include up to 60 days in a hospital or 120 days in a medically certified nursing home. Insured individuals would have the privilege of choosing their own doctors. The government would negotiate directly with qualified institutions to provide medical care or with nonprofit insurance agencies such as the Blue Cross. The A.F.L.-C.I.O. estimates that the cost of this insurance would equal one-half of one per cent of payroll and could be financed by adding about $10 a year to the payroll tax.[18]

The American Medical Association now has under review a proposal for a similar program in which participation would be voluntary rather than compulsory. The plan was drawn up by the Commission on Geriatrics of the Pennsylvania Medical Society and introduced for consideration at an A.M.A. meeting last November.

Under this proposal a worker covered by Social Security could elect to participate in a health insurance plan to be financed through payment of one per cent of payroll—one-half by the employer and one-half by the employee. Social Security would act, in effect, as collection agent for a private, voluntary insurance system, utilizing the established machinery for payroll deductions. The special health fund would be available to retired workers for the following purposes: to meet payments for continuation of health insurance coverage enjoyed before retirement; to pay doctors' fees in accordance with regional agreements; to supplement hospital charges for unusual health situations; and to pay for periodic physical examinations.

Proponents of the plan estimate that one per cent of covered payroll, paid in regularly over the normal 40-year working span of an individual's life, would give at retirement an accrual of about $1,600, to which compound interest would add $1,200 to make a total of $2,800 held solely for medical payments. This figure is said to approximate estimated per capita medical costs, at current rates, for ten years of life after retirement.

It would take from 20 to 40 years for such a program

[18] Katherine Ellickson, "Toward Proper Health," *A.F.L.-C.I.O. Federationist*, July 1957, p. 12.

to become self-supporting. The group which drew up the plan recommended that the government in the meantime make a direct contribution to the fund to defray medical costs of persons who had already retired or who would retire before they had paid in an amount sufficient to meet the costs of benefits.

New Programs to Maintain Good Health

GROWTH of the number of old persons in the population has led many states and communities to establish new facilities, or to reorganize existing facilities, to help keep the elderly in good health and in condition to make useful contributions to society. The trend in public health programs for the aged is toward prevention of ill health and toward rehabilitation. A public health doctor observed last year that "We should make sure that the money we spend for our older population is wisely spent, not for more drugs and more beds—mere custodial care—but for the newer diagnostic, rehabilitation, and other services which will truly advance the health of the aging." [19]

Howard Pyle, a White House deputy assistant, told the Federal-State Conference on Aging on June 5, 1956, that the objective of current programs should be to "help make it possible for older persons to continue their productive lives . . . [and] to improve their health." Congress likewise declared, in legislation last year liberalizing federal aid to state programs for the needy, that its purpose was to encourage the states to set up services for the aged which would lead to self-help and independent living for elderly people.

Increases in Medical Benefits for Needy Aged

The Council of State Governments recently reported on numerous new programs designed to shore up the income of the aged and to assure them of more medical attention. Some of the state programs have been altered to take advantage of new federal grants allowed by the 1956 amendments to the Social Security Act. The amendments not only increased the federal share of direct cash payments

[19] Dr. Lester Breslow at Federal-State Conference on Aging, Washington, D. C., June 5-7, 1956.

to the indigent aged[20] but also authorized dollar-for-dollar federal sharing with the states of payments to suppliers of medical care (including payments for health insurance premiums) up to $6 a month times the number of recipients of old-age assistance.[21] The new medical care benefits, which became available on July 1, 1957, are over and above those for direct support of the needy.

Many of the states have raised old-age assistance benefits to bring them more closely in line with medical as well as basic living needs. Some have increased the maximum allowance under old-age assistance, and others have allowed exceptions to the maximum allowance to meet such special needs as costs of illness. Ohio in 1955 eliminated a $200 ceiling on medical care furnished by the state Division of the Aged. Although public assistance payments in that state are limited to $65 a month, additional payments may be made for "medical, surgical, dental, optometrical, hospital or necessary nursing and convalescent care and medical supplies and drugs."

Colorado in 1956 established a $5 million fund to finance health and medical care not obtainable under basic payments to the needy aged. Massachusetts two years earlier instituted a state-wide medical care program for old age assistance recipients to provide them with doctor's care, diagnostic services, drugs, hospitalization, eyeglasses, visiting nurse services, and nursing home care. Several states have established pool funds out of which payments for special medical needs of the aged may be drawn.

Efforts to Keep Old People Out of Institutions

Some of the states have initiated programs to hold down the number of aged persons in public institutions, particularly mental hospitals. According to the Council of State Governments, "A number of states are convinced that many older persons now in mental institutions . . . could be cared for and treated more appropriately in special geriatric facilities or well-equipped and staffed homes for aged and chronically ill." Certain states have enacted laws prohibiting committal to mental institutions of aged persons

[20] The federal share was increased from four-fifths of the first $25 of the average monthly payment plus one-half of the next $30, to four-fifths of the first $30 plus one-half of the next $30. The federal share thus was raised from a maximum of $35 a month to a maximum of $39.

[21] The federal share is accordingly limited in each state to $3 a month times the number of the state's needy aged.

who do not require psychiatric treatment. Many harmless senile persons are in this category; they can be cared for more satisfactorily and at less cost in boarding homes.

Kansas and North Carolina are among states that follow new screening and diagnostic procedures, along with social services, to hasten the discharge of aged patients from hospitals. Other states are developing home service programs and day-hospital and out-patient facilities specifically for older persons who might otherwise have to be hospitalized. New York's Bureau of Chronic Disease and Geriatrics, established in the state health department in 1956, is required by law to explore possibilities for improving the care of the chronically ill while reducing its cost. The national Hospital Construction Act was amended in 1954 to make $60 million of federal matching funds available annually for three years to help finance construction of facilities for the chronically ill, out-patient diagnostic facilities, rehabilitation centers, and nursing homes.

Rehabilitation programs have succeeded in returning many oldsters to a fairly active life. The Allegheny County (Pa.) Home for the Aged has reported that rehabilitation activities enabled it to discharge more than one-half of its disabled and chronically ill inmates; some persons who were arthritic and others who had suffered strokes, amputations or fractured hips actually returned to work. The King County (Wash.) Hospital Extension Service, which includes instruction of family members among its services, brought about the discharge of 124 long-term hospitalized cases in a single year. The home care program of Montefiore Hospital in Pittsburgh was credited with reducing per-patient costs from an average of $14.49 a day to an average of $7.25 a day.

Expansion and Improvement of Nursing Homes

A "last extremity" facility for the infirm is the nursing home. A recent survey by the Commission on Chronic Illness and the U.S. Public Health Service found that there were 25,000 nursing homes in the country, that together they had 450,000 patients, and that the average age of the patients was 80 years. Most of the homes are commercially operated, but the larger ones are supported by public or voluntary agencies. One-fifth of the patients are completely bedridden, nearly one-half cannot walk without sup-

port, and more than one-half are "disoriented" at least a part of the time.

The survey found much variation in the quality of the homes, but in general they were "rather divorced from the mainstreams of medical care." Sixty per cent of the proprietary homes employed no professional nurses. A recent 20th Century Fund study described the grim conditions which prevail in many such places:

> . . A visit to a typical nursing home is a sobering experience. A considerable proportion of the "guests" are elderly people waiting to die. There are frequent instances of neglect, even among persons able to pay their way. Many homes provide no regular medical supervision of patients. . . . Some . . . seem to keep patients in bed as much as possible to minimize supervision by attendants. . . . Rehabilitation is seldom attempted.[22]

State agencies participating in a joint study of aging last year recommended expansion of diversified facilities for group care of the aged—old age homes, cottages, nursing homes, infirmaries—and said at the same time that such facilities should be brought into closer relationship with other community institutions, including hospitals.[23] The Federal-State Conference on Aging dealt at length with high fees charged at nursing homes; some conferees felt "domiciliary care was being paid for at a high rate in nursing homes under the guise of medical care."[24]

Prospects for Bettering the Health of the Aged

Many observers think the health problems of the aged will become less acute as time passes. They suggest that many of the present difficulties derive from the comparative suddenness with which society has been confronted with unprecedented numbers in the old-age segment of the population. As the Social Security system matures, fewer persons will be living on substandard income in retirement. Expansion of medical insurance promises better health care throughout life. Medical research already is bringing new diagnostic and treatment techniques into play which keep the afflicted active and able to care for themselves. Eventually it may find the key to control of the degenerative and chronic diseases to which the aged are most prone.

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[22] John J. Corson and John W. McConnell, *Economic Needs of Older People* (1956), p. 24.

[23] Council of State Governments, *Recommended State Action for the Aging and the Aged* (1956), p. 21.

[24] Council of State Governments, *Mobilizing Resources for Older People* (1956), p. 83.

The very extent of society's concern for the welfare of persons in the upper age brackets gives a boost to the morale of the aged and has beneficial effects on their physical and mental health. More than half the states have special agencies directed to the interests of older persons—either governors' commissions, legislative committees, or citizens' groups with quasi-official status. There is a trend toward creation of geriatric sections in state public health offices.

It is generally recognized that health programs for the aged must not be confined to medical problems, that they must be linked with activities which make for a fuller life in the later years. Efforts to provide employment for the aged are of utmost importance. Doctors have found that "Retirement, loss of direction and motivation cause disturbances in no way related to actual physical aging of the body" which nevertheless produce "deterioration of personality, frequently a depressive reaction, and . . . a tremendous accelerating in the aging process." [25]

An anthropologist has suggested that as the number of older persons in the population increases, "Our community can, and probably will, create . . . a brave new climate in which to grow old." In all societies, he points out, "The plain folk have aged most successfully when they have discovered and developed for themselves effective places and functions in the very societies of which they are a part." [26]

[25] Dr. Benjamin Boshes of Northwestern University Medical School, quoted in *Science News Letter*, Apr. 13, 1957, p. 237.

[26] Leo W. Simmons, "An Anthropologist Views Old Age," *Public Health Reports*, April 1957, p. 294.